PROVIDER'S REQUEST FOR ADJUSTMENT

Dept of Labor and Industries
PO Box 44269
Olympia WA 98504-4269

DO NOT WRITE IN SPACE >

CHECK ONE →

- ☐ NO PAYMENT - DO NOT USE THIS FORM. (SEE REVERSE SIDE FOR INSTRUCTION.)
- ☐ TOTAL /PARTIAL OVERPAYMENT
- ☐ PARTIAL UNDERPAYMENT

INSTRUCTIONS APPEAR ON REVERSE SIDE

Please type or print in dark ink

1) Worker's name Last First M. Initial	2) Claim number on remittance advice
3) Provider name	4) ICN number on remittance advice (17-digit number)
5) L&I provider number used on original bill	

SUBMIT ONLY ONE FORM FOR EACH ICN
ENTER ONLY THE INFORMATION YOU WANT CHANGED

6 Line Item No	a) From/to Date of Service or Covered Dates	b) POS	c) TOS	d) Procedure Code/ Revenue Code/NDC	e) Code Mod	f) ICD-9-CM Diagnosis/ Side of body	g) Tooth No	h) Charge	i) Days/ Units/ Qty	j) Days supply	k) Description

REASON FOR ADJUSTMENT: Write the reason for your request. Example: *2 units were billed in error; should have billed 6 units.* Attach required reports and/or other documentation necessary to support your request. A copy of the original bill is also helpful**.**

Date	Phone number ( )	Signature

RESET

ADJUSTMENT REQUEST FORM

IF YOUR ORIGINAL BILL WAS DENIED IN FULL, DO NOT USE THIS FORM. PLEASE SUBMIT A NEW BILL.

THE ADJUSTMENT REQUEST FORM MAY BE USED IN THE FOLLOWING INSTANCES:

TOTAL OVERPAYMENT ----- Entire bill was paid in error. You may either submit an Adjustment Request Form and we will process a credit to recover the money from your future payment(s); OR you may issue a refund check directly to the Department. If a refund is submitted, you must attach a copy of the remittance advice indicating the Internal Control Number (ICN) overpaid. Submit refunds to:

Cashiers Office
Department of Labor and Industries (L&I)
PO Box 44835
Olympia WA 98504-4835

PARTIAL OVERPAYMENT --- A portion of the bill was overpaid. Complete Adjustment Request Form with correct information for the procedures/items paid incorrectly.

UNDERPAYMENT ---------- A portion of the bill was underpaid. Complete adjustment request form with correct information for the procedures/items paid incorrectly. Corrections or justification and/or reports must be included.

INSTRUCTIONS FOR COMPLETING ADJUSTMENT REQUEST

1. **WORKER'S NAME:** Clearly print injured worker's full name.
2. **CLAIM NUMBER ON REMITTANCE ADVICE:** Enter the 7-digit number found in the Claim Number column on the remittance advice.
3. **PROVIDER NAME**: Enter the name of the provider who performed these services.
4. **ICN NUMBER:** Enter the 17-digit number found in the ICN column on the remittance advice, to identify the ICN needing correction.
5. **L&I PROVIDER NUMBER:** Enter the L&I provider account number that was used on the original bill.
6. **SERVICE ITEMIZATION:** Enter the line item number(s) that corresponds to the line item number on your original bill. Enter **ONLY** the information you want to correct, as it should have appeared on your original bill. *Example: 2 units of service billed on line 3 and should have billed 6 units. Enter line item number 3 in column 6 and 6 in column i.*
   a. **From/to Date of Service or Covered Dates:** Date of service, from and to date if date span previously billed. Admit and discharge date for hospital bill.
   b. **Place of Service:** (POS) Two digit code identifying the place service was performed.
   c. **Type of Service:** (TOS) One digit code identifying the type of service performed.
   d. **Procedure Code/Revenue Code/NDC**: Identify correct procedure, hospital service or national drug code.
   e. **Code Mod:** Modifier used to identify special circumstances for a service or procedure.
   f. **ICD-9-CM Diagnosis/Side of Body:** ICD-9-CM diagnosis code for condition treated. Designate left or right side of body where applicable.
   g. **Tooth Number:** For dental services only. Enter the two digit identification number of the specific tooth number treated (e.g., 08).
   h. **Charge:** Total of charges for services provided this line.
   i. **Days/Units/Quantity:** Total days stay for hospital accommodation codes, unit of service for procedure (time units, hours, miles, etc.), number of items (tablets, milliliters, etc.).
   j. **Days Supply:** Total number of days a prescription is intended to cover.
   k. **Description:** Describe procedure or service.

If you have questions completing this form, please call Provider Hotline at 1-800-848-0811.